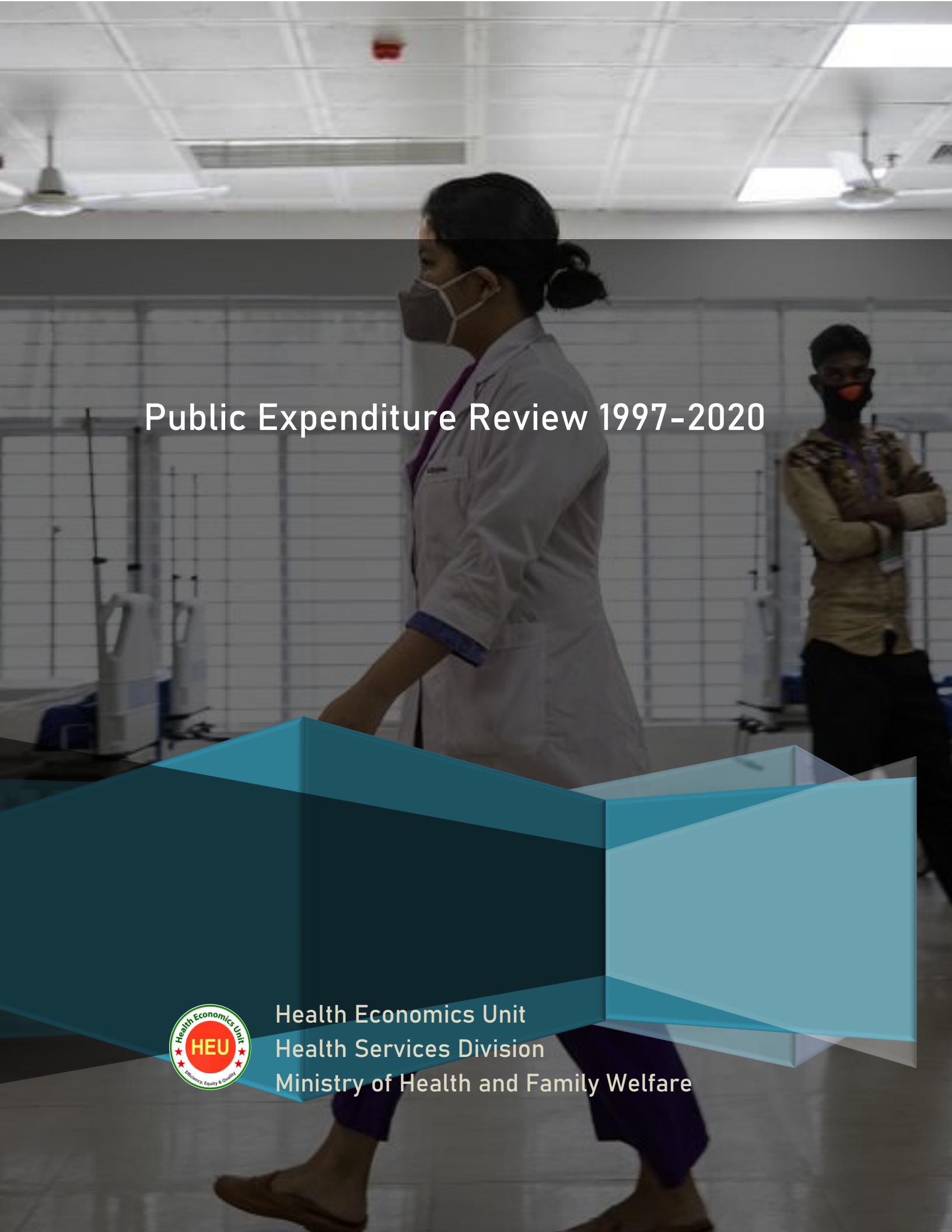


Public Expenditure Review 1997-2020

Health Economics Unit
Health Services Division
Ministry of Health and Family Welfare

Public Expenditure Review of the Health Sector

1. Introduction

This review of public expenditure on health is the eleventh review conducted by the Health Economics Unit (HEU) of the Ministry of Health and Family Welfare (MOHFW) since its inception in 1995. HEU is mandated to produce Public Expenditure Review (PER) for the health sector and also National Health Accounts (NHA). Each round of the PERs has different focus, which is determined by the prevailing situation or challenges in the health sector or issues that require attention for future policy direction.

Budget and expenditure are key to achieving sectoral policy goals. It is important to examine the policy framework as well as budgetary and expenditure framework, which in turn will help to understand whether budget allocation and expenditure patterns support the strategic priorities in health, population and nutrition sector.

1.1 Sectoral policies and priorities

A number of policy and planning documents that laid out the policies and strategies for the health sector have been reviewed and summarized in this sub section. The Five-Year Plans (FYPs) have been the main policy documents that laid out the strategies for the government development programs in different sector since 1973. The Sector Investment Plan (SIP) guiding the health sector programme is aligned with FYP. The current sector progeamme the 4th HPNSP (4th Health Population and Nutrition Sector Programme) 2017-2023 is guided by the HNPSIP 2016-2021.

The Seventh Five Year Plan (2015/16-2019/20) and Health, Nutrition and Population Sector Investment Plan (HNPSIP) 2016-2021 are the two policy documents are relevant for this PER. Periods covered under these two planning documents coincide with the period covered by this PER (2015/16-2019/20).

All plans underscored the importance of health sector by increasing sectoral allocation for health. The Seventh FYP envisaged the allocation to be at least 1.2% of GDP by the end of the FYP period. The FYP allocated 5.7% of the planned public outlay (Taka 725,230 crore) for the health sector. HNPSIP 2016-2021, advocated for increased budget allocations for health, exploring new and innovative financing sources and also for increased Development Partner (DP) funding.

1.2 Objectives of PER

The objective of this PER is to examine the trends in public spending during FY 2016-20 in order to assess performance of MOHFW over the period.

This PER will examine inter alia the following:

- How much does the public sector spend? How much does MOHFW (HSD & MEFWD) spend?
  (Public sector includes MOHFW, other Ministries such as Ministry of Defense, Ministry of Home Affairs and so on.)

- How is the health expenditure financed? How much is GOB contribution vis-à-vis that of development partners?
- What is financed/spent by function and inputs for MOHFW (HSD & MEFWD) (e.g. salary, equipment, drugs, etc.?
- Are MOHFW resources being used efficiently? (
- Does MOHFW spending ensure equity? Does it reach the poorest group of the population or the poorer districts/upazilas?

1.3 Organization of the report

After a brief introduction on government policies and strategies Section 2 of this report describes the methodology adopted for documentation of this review. Public expenditure as estimated by BNHA, and MOHFW budget and expenditure are analyzed in Section 3. Section 4 examines efficiency of public expenditure in HPN sector. Equity of utilization of public expenditure on health is examined in Section 5. Section 6 discusses challenges in conducting regular PER and suggests a way forward. Section 7 concludes with recommendations.

2 Methodology and data sources

2.1 Scope of PER

This PER follows the NHA approach. In NHA public expenditure on health includes spending by MOHFW as well as by other ministries that incurred health related expenditure. These ministries include Ministry of Defense, Home Affairs, Social Welfare, Local Government and Rural Development and so on. As stated in the preceding section this review covers the period between 20115/16 and 2019/20.

MOHFW expenditure analysis under this PER differs from the BNHA. Since BNHA estimates health spending of all sectors (government, households, private firms, NGOS, Development partners) in order to avoid double counting in BNHA, revenues (including user fees) collected by MOHFW are subtracted from MOHFW expenditure. There is no need for such subtraction as PER analyzes MOHFW expenditure only.

2.2 Data Sources

This review used a range of data sources. These include: (i) iBAS ++ (Integrated Budget and Accounting System) from the CGA (controller General of Accounts), Ministry of Finance (MOF), the main source for expenditure analysis. (ii) Line Directors (LD) implementing the sector wide program, ((iii) budget briefs (www.mof.gov.bd), (iv) MOHFW Revenue budget books, (v) ADP Monitoring report from the Planning Wing of HSD and MEFWD of the MOHFW, and (vi) poverty mapping of district and upazilas by Bangladesh Bureau of Statistics (BBS) with support from World Food Programme (WP) and the World Bank[1].

2.3 Data explanation

BNHA excludes pension from the government spending on health. PER analyzes MOHFW spending net of pension expenditure. During XX-XX pension was included in the line ministry budget. However, since XX pension is no longer included in the budget. In order to maintain consistency the pension amount has been subtracted from the expenditure. Throughout the report MOHFW Operating budget (Non-development), revised Operating budget and actual Operating expenditure exclude pension amount.

CGA data does not include Direct Project Aid (DPA). Therefore, detail analysis of development expenditure is exclusive of DPA. Moreover, development expenditure in CGA data cannot be disaggregated into Reimbursable Project Aid (RPA) and GOB contribution.

All figures relate to the fiscal year i.e. from July 1 to June 30. Throughout the report the mention of a year refers to a fiscal year (e.g. 1997 refers to fiscal year 1996-97).

All figures (except per capita figures) are in crore. Ten million makes one crore and a hundred crore is one billion.

GDP deflator (2005-06=100) was used for making adjustments for inflation i.e. converting current Taka into constant Taka.

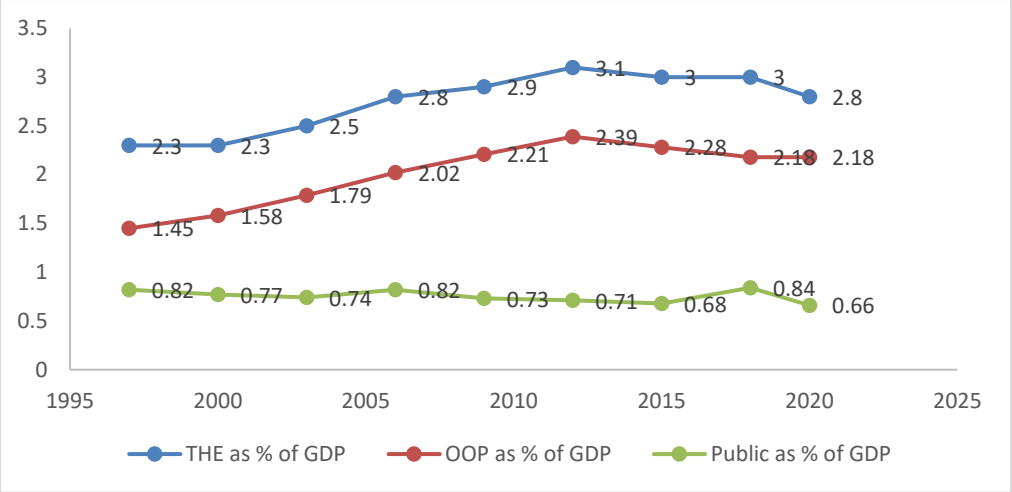
Data analysis was done using Microsoft Excel version 2016.

3. Trends in public spending on health

Bangladesh National Health Accounts (BNHA) estimated total health expenditure (THE) from all sources for 1997 - 2020. THE in 2020 was Taka 777 billion accounting for 2.8% of GDP (BNHA 1997-2020). In the same year government spending on health was Taka 179.74 billion representing 23% of THE (0.66% of GDP).

The general trend in THE as a proportion of GDP during 1997-2020 has been rising and averaged around 3%. In contrast, the government spending as a share of GDP has been falling and remained around less than one percent (<1%) throughout the period while falling more sharply in 2020 to 0.66% (BNHA 1997-2020). This is contrary to the international trend for public expenditure on health to increase as a share of GDP as per capita income rises. Clearly, government spending was not responsive to rising income level rather it was household spending that contributed to increasing THE.

Figure.1: Ratio of Health Expenditure to GDP, 1997-2020



Source: BNHA 1997-2020

As demonstrated in Figure.1, Public health spending as a proportion of GDP was 0.66% in 2020. Table. 1 shows that this public health spending as a proportion of CHE was 17% which is lower than all other South Asian countries with the exception of Afghanistan (5%) which has the lowest figures in the region.

Table.1: Total health Expenditure (THE) and Public Spending on health in selected countries, 2020

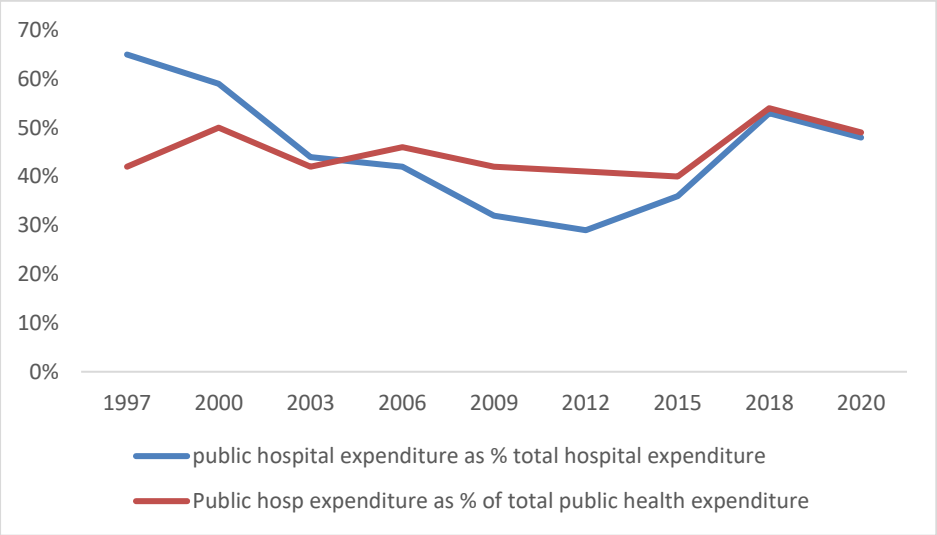
Countries	Current Health Expenditure (CHE) as % Gross Domestic Product (GDP)	Current Health Expenditure (CHE) per Capita in US$	Domestic General Government Health Expenditure (GGHE-D) as % Current Health Expenditure (CHE)	Out-of-pocket (OOPs) as % of Current Health Expenditure (CHE)
Bangladesh	**2.30%**	**$42**	**17%**	**74%**
BNHA-CHE	*2.70%*	*$45*	*21%*	*71%*
BNHA-THE	*3.00%*	*$50*	*22%*	*69%*
Afghanistan	9.40%	$50	5%	78%

Bhutan	3.10%	$103	80%	13%
India	3.50%	$73	27%	63%
Maldives	9.40%	$974	71%	21%
Nepal	5.80%	$58	25%	51%
Pakistan	3.20%	$43	36%	56%
Sri Lanka	3.80%	$157	41%	51%

Sources: BNHA 1997-2020 and Global Health Expenditure Database, WHO

Government Health Expenditure was further analysed by providers. Spending at public hospitals as a proportion of the total government health expenditure rose from 42% in 1997 to 49% in 2020. Whereas, Public hospital spending as a proportion of total hospital spending declined form 65% in 1997 to 48% in 2020 (Figure.2), indicating the growing share of private sector (including NGOs).

Figure.2: Share of Curative and preventive care in Public Health Expenditure

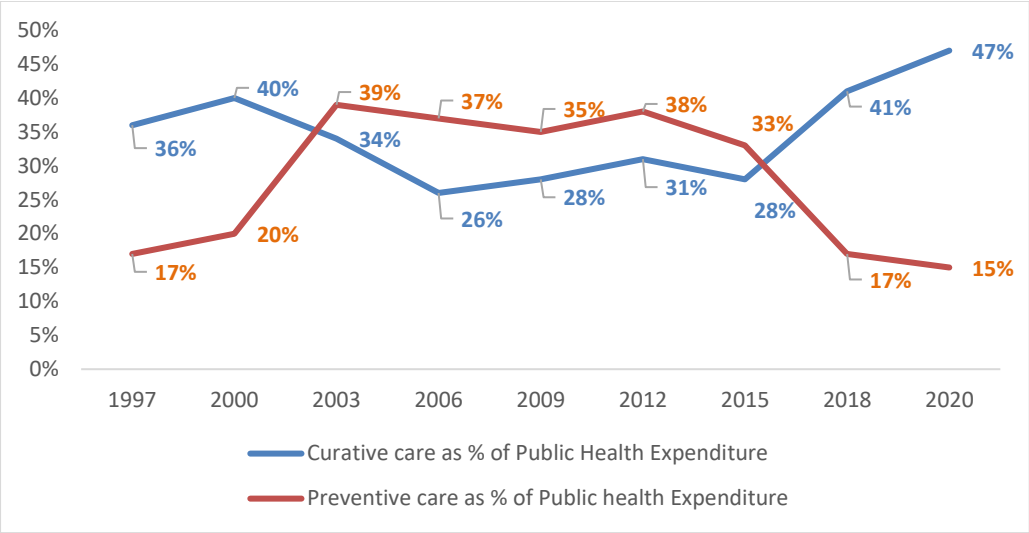


Source: BNHA 1997-2020

An examination of the total public health expenditure by function revealed that the proportion of government spending on curative care increased while the share of preventive care decreased between 1997 and 2020. In 1997 their respective share was 36% and 17% of the total public health expenditure. In 2020 the share of curative care increased to 47% while the share of preventive care dropped to 15%. However, it is important to note that the share of preventive care as a proportion of the public health expenditure was higher between 2003 (39%) and 2015 (33%) whereas, the share of curative care as a proportion of the public health expenditure was lower by comparison and only increased post 2015 (28%). A possible explanation for these findings lie within the fact that the

government upscaled disease control and prevention programmes in this period while a massive upscaling of hospitals and other facilities designated for curative healthcare took place from 2015 (Figure.3)

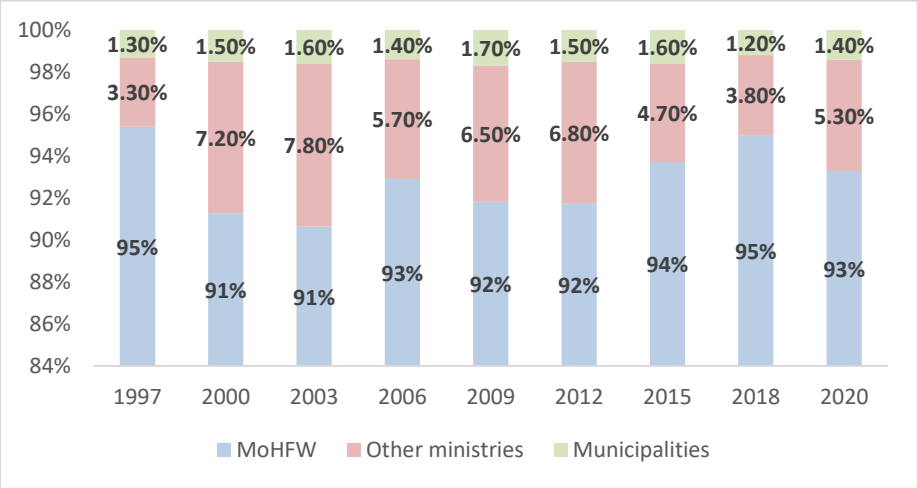
Figure.3: Share of curative and preventive care in Government health Expenditure, 1997-2020



Source: BNHA 1997-2020

Government spending on health comprises spending by Ministry of Health and Family Welfare (MOHFW) and other ministries such as Defence, Home Affairs, Social Welfare and Local Government. During 1997-2020 MOHFW spending averaged >90% of the government spending on health. Hence, MOHFW expenditure warrants a closer examination.

Figure.4: Distribution of Government Health Financing Scheme in BNHA 1997-2020



Source: BNHA 1997-2020

The results from BNHA 1997-2020 shows that the government's share in the total health expenditure (THE) has been on a declining trend during 1997-2020 and remained <1% of the GDP throughout the period. Further analysis of the government health spending reveals that the proportion of the government health expenditure on hospitals gas decreased during the same period. Although preventive care received higher proportion of public health expenditure between 2003 and 2015, curative healthcare received a higher share post 2015.

4.1 Trends in MOHFW budget

This section examines MOHFW budget that includes both Revenue (non-development) and Development budget (Annual Development Program or ADP). The Revenue budget is solely financed by the Government of Bangladesh (GOB) while the Development budget is financed by both GOB and Development Partners (DP).

Both Revenue and Development budgets get revised half way through each fiscal year. Hence, original as well as revised budget is also examined.

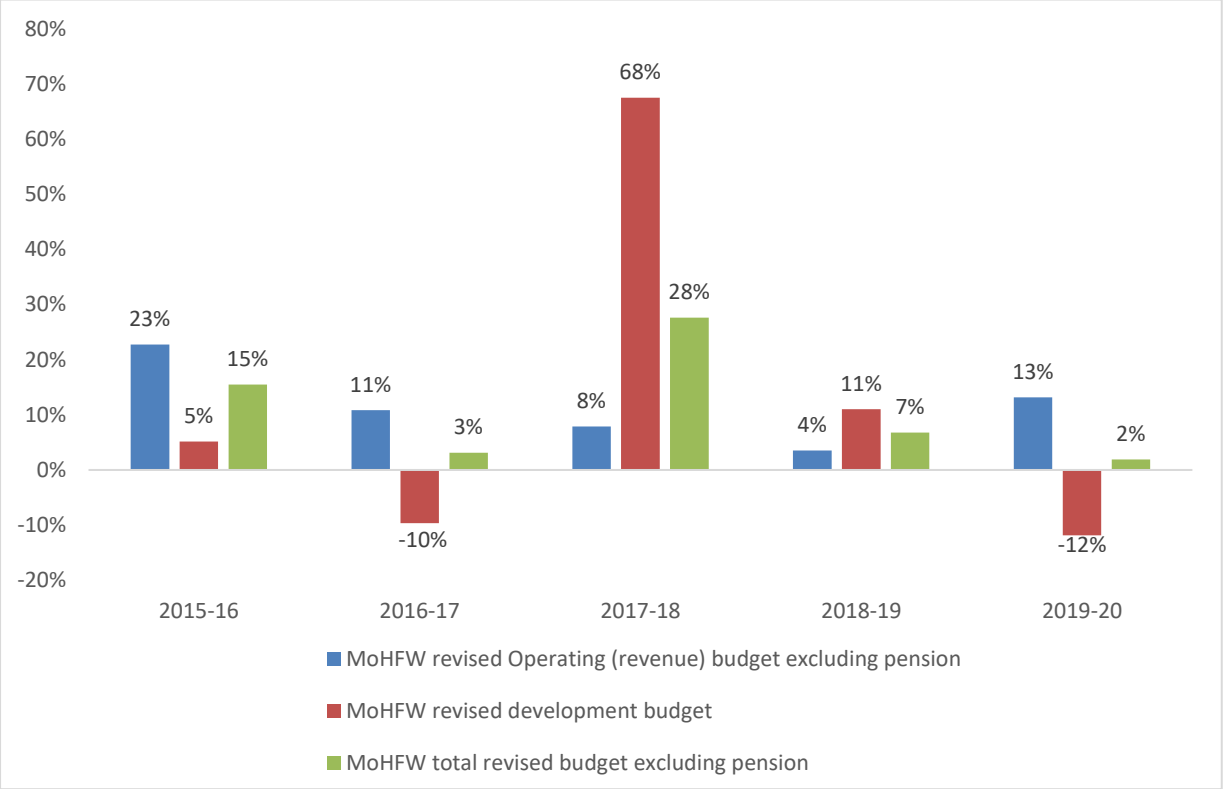
Revised budget allocation (excluding pension) to MOHFW also increased more than fourteenfold since 1997 to taka 23,692 crore in 2020 in nominal terms (Table 1).

Table 1: MOHFW revised budget, 1997-2020

	Current crore Taka			Constant crore Taka (2005-06=100)		
Year	MOHFW revised revenue budget excluding pension	MOHFW revised development budget	MOHFW revised budget excluding pension	MOHFW revised revenue budget excluding pension	MOHFW revised development budget	MOHFW revised budget excluding pension
1997	769	991	1760	1137	1465	2602
1998	833.7785	1151	1985	1177	1625	2801
1999	894.0043	1193	2087	1216	1622	2837
2000	972.3559	1391	2363	1278	1828	3106
2001	1099.074	1528	2627	1399	1945	3344
2002	1286.15	1363	2649	1576	1670	3246
2003	1333.688	1463	2797	1544	1694	3238
2004	1496.724	1848	3344	1657	2046	3703
2005	1802.981	1372	3175	1909	1452	3361
2006	2064.263	2047	4111	2064	2047	4111
2007	2450.771	2275	4726	2302	2137	4439
2008	2640.264	2363	5003	2299	2058	4357
2009	3317.969	2615	5933	2706	2133	4839
2010	3838.245	2829	6667	2922	2153	5075
2011	4518.325	2736	7254	3189	1931	5120
2012	4628.459	3036	7664	3020	1981	5001
2013	4872.65	3623	8496	2966	2206	5172
2014	5718.5	3816	9535	3295	2199	5493
2015	6439.789	4562	11002	3504	2483	5987

2016	8438.408	5121	13560	4303	2611	6914
2017	9940.164	4918	14858	4769	2359	7128
2018	11323.37	8700	20023	5144	3952	9097
2019	12249.03	10091	22340	5327	4389	9716
2020	14431.49	9261	23692	6030	3870	9900

Figure: 1 Average real growth rate for MOHFW revised budget 1997-2020



MOHFE revised Revenue budget experienced faster growth than revised Development budget in real terms during 2015-2020. Highest growth (68%) for MOHFW revised Development budget was observed in 2017-2018.

MOHFW revised budget and revised Development budget as a ratio to GDP have been on declining trend and remained below one percent from 2015 to 2017, however, the trend remained more or less constant in 2020. In contrast, revised Revenue budget as a proportion of GDP shows a slightly increasing trend (Figure 2).

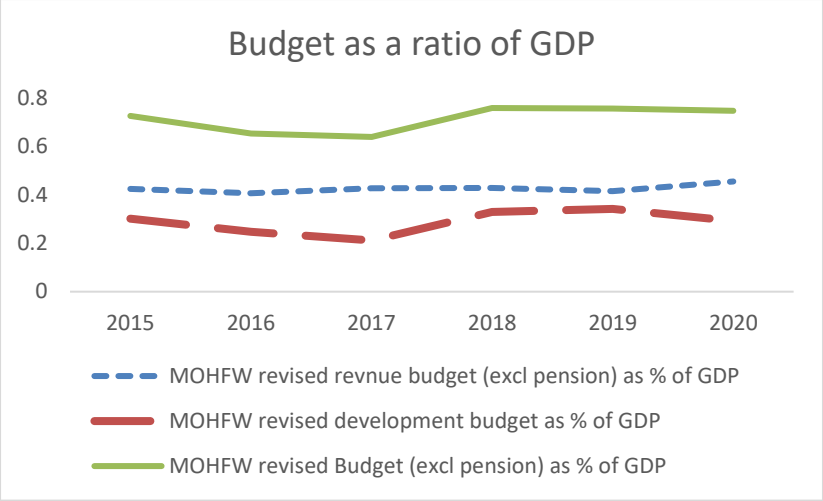


Figure 2: MOHFW revised budget as a ratio to GDP, 1998-2020

4.2 Trend in MOHFW expenditure

This section examines MOHFW expenditure during 1997-2020. As stated earlier that revenue collected by MOHFW has not been subtracted from MOHFW expenditure as was done for BNHA analysis.

Table 3 shows that nominal MOHFW expenditure (excluding pension) grew from Taka 1665 crore in 1997 to Taka 17138 crore in 2020, representing a tenfold increase in nominal term and in real term it almost trippled.

MOHFW expenditure is financed by both Non-development and Development budget. Non-development budget is solely financed by the Government of Bangladesh (GOB) while development budget is financed by both GOB and Development partners (DP). DP funding consists of grant and soft loan. Share of development expenditure has declined over time from 54% in 1997 to 37% in 2020.

Table 3: MOHFW expenditure, 1997-2020

	Current crore Taka			Constant crore Taka (2005-06=100)		
	MOHFW Revenue exp	MOHFW Development exp	MOHFW total exp current	MOHFW Revenue exp	MOHFW Development exp	MOHFW total exp constant
1997	769	896	1665	1137	1324	2461
1998	813	915	1728	1147	1291	2438
1999	891	924	1815	1211	1257	2468
2000	963	943	1907	1266	1240	2506
2001	1041	1152	2193	1325	1466	2791
2002	1205	1192	2398	1477	1461	2938
2003	1298	1047	2345	1503	1212	2715

2004	1448	1338	2786	1603	1482	3085
2005	1704	1136	2839	1804	1203	3006
2006	1936	1768	3704	1936	1768	3704
2007	2241	1701	3942	2105	1597	3702
2008	2342	1960	4302	2039	1707	3746
2009	2870	1935	4805	2341	1578	3919
2010	3397	2468	5865	2586	1878	4464
2011	4171	2551	6722	2944	1800	4744
2012	4404	2612	7016	2873	1704	4578
2013	4631	3317	7948	2819	2019	4838
2014	5483	3416	8899	3159	1968	5127
2015	6080	3668	9748	3309	1996	5305
2016	7585	3657	11242	3868	1865	5732
2017	9060	4204	13263	4346	2017	6363
2018	9750	8239	17989	4430	3743	8173
2019	10207	7862	18069	4439	3419	7859
2020	10778	6359	17138	4504	2657	7161

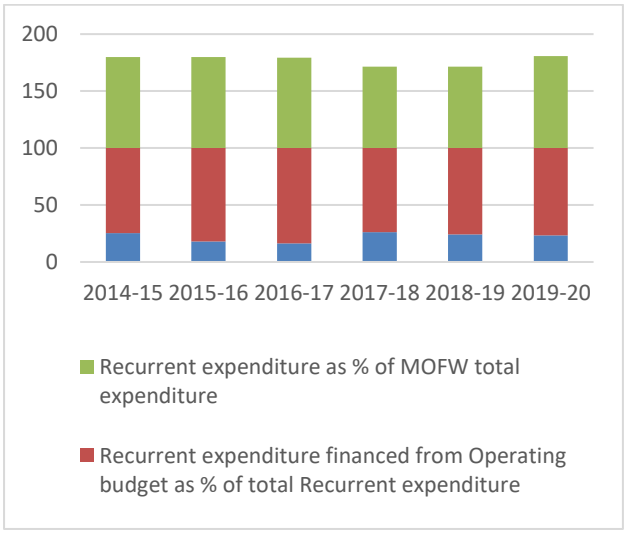
Source: CGA for 1997-2020 figures and MOF Budget unit 2016-2020 figures

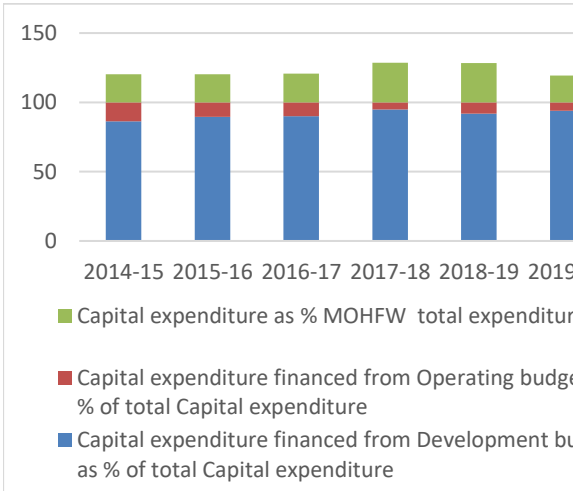
Per capita MOHFW expenditure in real terms has increased by 20% since 2015. In real terms per capita revenue spending increased by 70% between 2015 to 2020 while real per capita MoHFW development spending increased by 18% during the same time (Annex table 4).

4.2.1 Line item wise expenditure

MoHFW expenditure is categorized into recurrent and capital expenditure. Each in turn is examined by line items. Figure 8 shows the dominance of recurrent expenditure in the total MoHFW expenditure averaging 80% throughout 1997-2020. Revenue budget has been the dominant source of financing of financing for MoHFW recurrent expenditure.

Capital expenditure on average accounted for one fifth of MoHFW spending during the same period. Historically development budget has been the main source for financing capital expenditure. However, the share of the revenue budget has been financing lower than 10% of capital expenditure since 2016 (Figure 8).





4.2.1.1 Capital expenditure

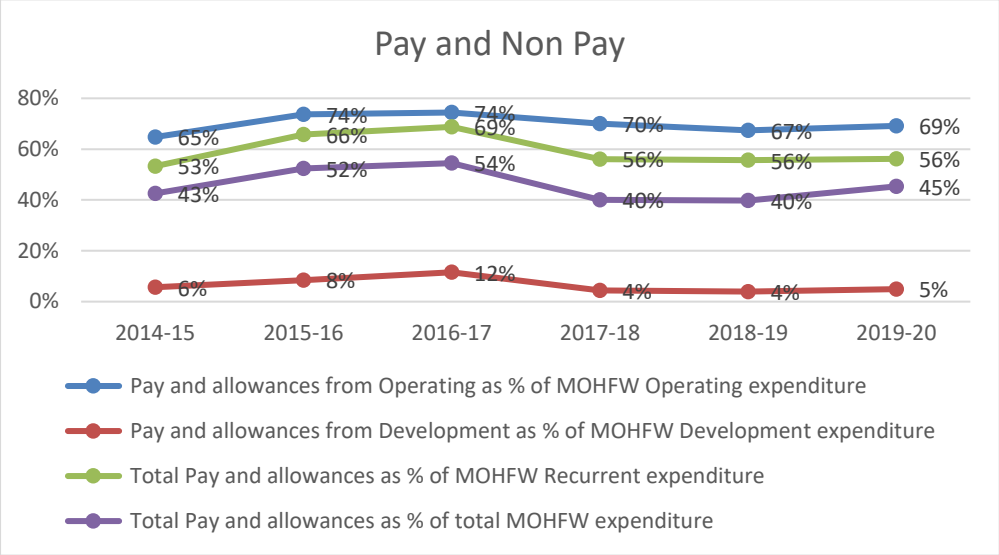
Spending on two capital line items – medical equipment and construction works is examined further

4.2.1.2 Recurrent expenditure

Pay and allowances

The MoHFW expenditure on pay and allowances grew from taka 969 crore in 1997 to taka 7768 crore in 2020.

Figure 9: Pay and non pay



Medicine and medical supplies:

Development Spending on MSR rises from 350 crore to 1352 crore from 2015 to 2020 while spending from operating rises almost double during the same time.

Year	Total MSR and Medicines and vaccines from Development	Total MSR and Medicines and vaccines from Operating	Total MSR and Medicines and vaccines expenditure
2014-15	350.00	706	1,056
2015-16	468.00	802	1,270
2016-17	417.00	942	1,359
2017-18	1,070.00	1,297	2,367
2018-19	1,024.00	1,509	2,533
2019-20	1,352.00	1,467	2,819

Fig: MSR

Per capita spending rises 4 times in the same period while per capita out of pocket spending rises from 1192 taka to 2028 taka.

Year	Per capita MOHFW MSR spending	Per capita OOP drugs
2014-15	22.32	1,192.78
2015-16	29.21	1,423.29
2016-17	25.61	1,521.86
2017-18	64.81	1,657.53
2018-19	61.13	1,816.83
2019-20	79.62	2,028.10

Year	Total MSR and Medicines and vaccines from Development	Total MSR and Medicines and vaccines from Operating	Total MSR and Medicines and vaccines expenditure
2015	350	706	1,056
2016	468	802	1,270
2017	417	942	1,359
2018	1,070	1,297	2,367
2019	1,024	1,509	2,533
2020	1,352	1,467	2,819

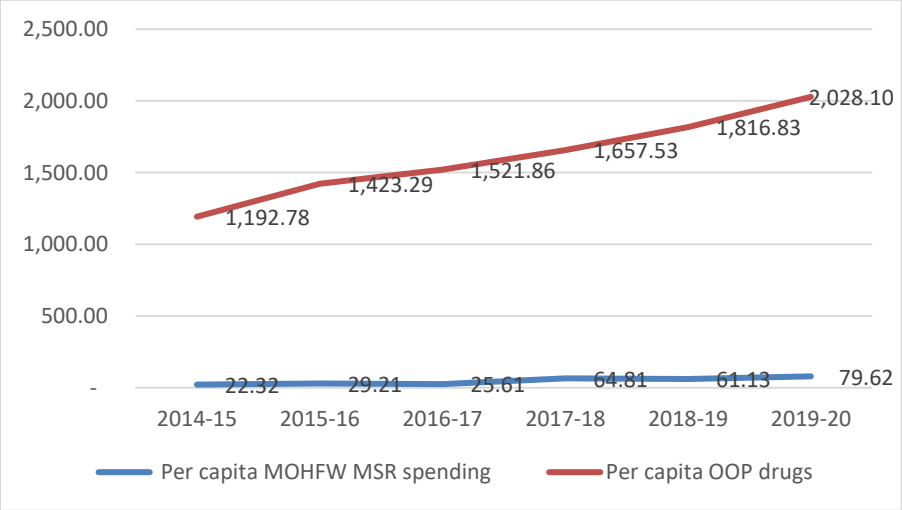


Figure: Comparison between per capita MSR spending vs per capita OOP spending on drugs

Contraceptives:

MOHFW spending on contraceptives has been increasing during 1997-2020 with occasional declines and mainly financed from development budget. In 2020, contraceptives worth of Taka 319 crore was procured while it was 0.39 crore in 1997.

MOHFW Contraceptives

Year	Development	Operating	Total
2015	218	95	312
2016	64	70	134
2017	132	104	236
2018	197	120	317
2019	338	104	442
2020	201	119	319

Medicines and Vaccines has been dominantly spending from development budget from 2015 to 2020. In 2020, 983 crore taka was spent on this sector from development budget while only half crore from operating budget.

	Development	Operating	Grand Total
2014-15	198.7	0.001	198.7
2015-16	264.1	0.018	264.1
2016-17	257.0	0.002	257.0
2017-18	675.3	0.000	675.3
2018-19	631.1	0.220	631.3
2019-20	983.3	0.500	983.8

Training:

MOHFW spending on training constitutes a very small portion of the overall MOHFW spending. Spending on training rises from 156 crore to 293 crore in between 2015 to 2019 which is almost doubled.

Year	Advance for training	Domestic training	Training	Training Expenses	Grand Total
2014-15				156.15	**156.1**
2015-16		149.4			**149.4**
2016-17		78.0			**78.0**
2017-18		275.8			**275.8**
2018-19	0.06	18.2	299.92		**318.2**
2019-20		25.9	267.68		**293.5**

5. Assessing Efficiency in public expenditure

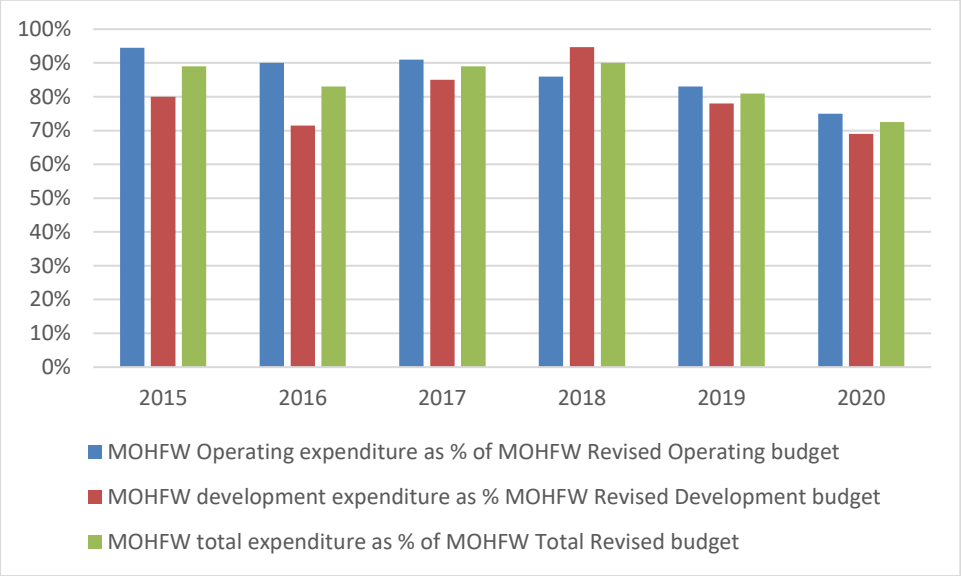
This section examines public expenditure to see whether public expenditure management helped improve efficiency in service delivery. Efficiency is examined in budget planning and budget execution, efficiency of service delivery at facility level, efficiency in terms of absenteeism among healthcare provider and use of medical equipment at various level of facilities.

5.1. Efficiency in budgeting and planning

As shown earlier that MOHFW cannot utilize its budget fully. Under-spending of revised budget is chronic. In order to identify which line items suffer from under-spending budget by line items (economic classification) was analyzed.

Year	MOHFW Revised operating budget as % of the total National Operating budget	MOHFW Revised development budget as % of the total National Development budget	MOHFW total Revised budget as % of the total National Revised budget
2014-15	4.67	5.97	5.11
2015-16	5.91	5.53	5.78
2016-17	5.14	4.37	4.86
2017-18	5.43	5.66	5.53
2018-19	4.59	5.82	5.08
2019-20	4.89	4.58	4.76

MoHFW operating expenditure as % of MoHFW revised operating budget drastically fall from 95% to 75% between the year 2015 to 2020. MoHFW development expenditure as % of MoHFW revised development budget fall from 80% to 69% during the same period.



5.1. Staff efficiency

From 1997 to 2020 average number of doctor in Upazilla Health Complexes (UHC) raises almost double while nurses almost rises four fold during this time.Unit cost per inpatient in UHCs was 2780 taka in 2020 while outpatient visit cost was 177 taka.

	1997	2010	2018
Inputs	UHCs		

Doctors (average number)	4.3	6.2	8
Nurses (average number)	6.3	9.5	21
Outputs			
Admission per year	2,347	4,043	7,195
Outpatients per year	50,228	81,431	57,835
Unit cost			
Cost per admission (current Taka)	1,938	1,962	2,780
Cost per outpatient visit (current Taka)	63	79	177

C

In 2015, Dhaka division shared the top in the public spending list while Sylhet was the lowest. The picture remains same in 2020 while Chattagram was second followed by Rajshahi and Rangpur.

Year	Barishal	Central	Chattogram	Dhaka	Khulna	Mymensingh	Rajshahi	Rangpur	Sylhet	Grand Total
2015	412.9	4504.8	971.7	996.6	726.4	405.3	728.1	658.5	344.2	9748.5
2016	508.8	4570.3	1239.8	1274.4	826.5	518.5	1023.7	839.5	440.9	11242.4
2017	582.7	5534.4	1482.2	1520.5	957.6	651.1	1137.4	895.3	502.1	13263.2
2018	674.7	8924.8	1672.4	1962.7	1118.1	693.1	1294.3	1031.0	617.8	17989.0
2019	790.1	6605.8	1822.6	3144.3	1372.4	828.3	1677.8	1140.5	687.4	18069.3
2020	865.7	6125.4	1802.5	2827.2	1267.5	830.6	1508.9	1162.3	747.6	17137.7

Spending on Dhaka division raises from 19% to 26% during the year 2015 to 2020 while share for Sylhet division remain same as 6-7% during the time. All other divisions almost in static for the same duration.

	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20
Barishal	8%	8%	8%	7%	7%	8%
Chattogram	19%	19%	19%	18%	16%	16%
Dhaka	19%	19%	20%	22%	27%	26%
Khulna	14%	12%	12%	12%	12%	12%
Mymensingh	8%	8%	8%	8%	7%	8%
Rajshahi	14%	15%	15%	14%	15%	14%
Rangpur	13%	13%	12%	11%	10%	11%
Sylhet	7%	7%	6%	7%	6%	7%

Regarding per capita expenditure, spending raises from 487 taka to 1084 taka during the year 2015 to 2020 while for Sylhet it only increases less than double on the same duration. Dhaka and Sylhet both were lowest in the poverty list while Rangpur was in the top list. For extreme poverty line, Dhaka was in the lowest while Rangpur was on the top.

	Per capita (current Taka) MOFW exp by division							
	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	Poverty	Extreme poverty
Barishal	840.0	910.4	1045.1	1379.7	1265.2	1349.7	27%	15%
Chattogram	542.6	592.0	709.3	912.5	778.8	750.0	18%	9%
Dhaka	487.1	560.9	670.8	987.2	1238.6	1084.4	16%	7%
Khulna	843.3	873.9	1014.9	1351.1	1298.8	1168.0	28%	12%
Mymensingh	648.9	743.3	935.5	1135.4	1062.7	1037.6	33%	18%
Rajshahi	725.1	910.3	1013.8	1315.3	1335.3	1169.3	29%	14%
Rangpur	722.4	841.3	899.4	1180.8	1022.9	1015.0	47%	31%
Sylhet	508.9	540.0	616.4	864.7	753.5	797.9	16%	12%

Challenges in conducting PER and Progress since the last PER

This section provides an update on the issues identified and recommendation made in the last PER.

Issues identified	Recommendation made in the last PER	Current status
For regular production of PER	• Close collaboration between HEU, The Financial Management and Audit Unit (FMAU) and Chief Accounts Officer (CAO) Health will not only ensure regular updating of PER but also facilitate improvement in data quality. In the past HEU produced two PER (2000 and 2001) jointly with FMAU. • The PER should be produced before October each year in order to inform budget preparation and budget revision. Therefore, preparatory activities need to start immediately after budget announcement to hasten data collection and clarifications.	
Data not available on time: This is a persistent problem. Although the Controller General of Accounts (CGA) has	• HEU will produce a PER with partial analysis for the latest fiscal year using unaudited data by broad economic code group in order to	For the latest one IBAS++ data available for 2019/20 in 2021, BNHA was planned for

been very cooperative in providing electronic data to HEU, the detailed data (for the latest fiscal year) is not accessible when needed. Generally it takes one year to finalize the audited accounts report though this time it took more than one year.	overcome the problem related to timely availability of detailed data. At the same time, it will also present detailed analysis for the fiscal year for which detailed and audited data by provider level (function code) is available. For example, the current PER provided detailed analysis up to 2012 and partial analysis of 2013 and 2014 for which data is available only by broad economic group. Next PER will update 2013 and 2014 analysis with detailed and audited data.	2018/19 and provisional estimates for 2019/20 based on budget data but later as CGA data were available that was not required.
Unmatched budget figures: Budget figures for the same fiscal year was found to be different in various budget documents (e.g. Budget Brief and Monthly Fiscal Report of the Ministry of Finance (MOF), MOHFW non-Development budget book, etc) including the iBAS (Integrated Budget and Accounts System) generated report. Perhaps it is due to inclusion or exclusion of some line items code, although it is not mentioned in the documents.	• It is commendable that MOHFW the detailed revenue (non-development) and Development budget (both original and revised) on its website. •	• Now uploads the detailed operating budget (both original and revised). • However, Development budget is not uploaded
Miscoding and missing code description: Missing codes description as well as miscoding makes classification of expenditure by provider and functions (services/activities) difficult.	• FMAU needs to develop a manual providing clear guidelines with adequate examples for correct coding of expenditure data. This will improve accuracy in data entry and also improve transparency.	

	• Coding for MSR needs to be revisited. There should be a code for medicines only and a separate code is required for medical and surgical supplies. This will enable a valid comparison between per capita MOHFW spending on medicines and per capita Out-Of-Pocket (OOP) payment on medicines. •	
Disaggregation of spending by DGFP facilities not possible: Facilities operated by the Directorate General of Family Planning (DGFP) are clustered under a single function code '2789' ('Hospital and Dispensaries') with a single operation code. This code includes facilities ranging from a 375 bed maternity hospital to a 10-20 bed Maternal and Child Welfare Centre (MCWC) and a small MCH Unit.	• DGFP needs a separate function code (or at least operation codes) for different tiers of its facilities, especially for MCWC. This will facilitate more accurate estimation of Reproductive, Maternal, Neonatal and Child Health (RMNCH) expenditure particularly at facility level.	• DGFP now has a code for 375 bed hospital • A separate code has been assigned for MCWC
Spending does not follow allocation: Revenue expenditure allocated for an institution located in a specific geographical area is being spent for another geographical location. For example, in 2012, 20% of Upazila Health Complex expenditure was recorded against central level and district level. This creates difficulties during		

classification of providers by geographical areas.		
Tracking of development expenditure by geographical location not feasible: As explained in Section 4.2.1.3 tracking of Development budget spending is not possible as this budget is allocated to Operation Plan (OP) or project, which is located centrally. Also, OPs do not show allocation to facilities or geographical location.	• MOHFW might consider developing own accounting system using open source software to capture DPA and disaggregating the development expenditure into Government, Reimbursable Project Aid (RPA), and Direct Project Aid (DPA) contribution. Open source software will make interface with iBAS feasible once MOF also updates iBAS to capture these data.	
Incorrect and absence of reporting: During efficiency analysis, the team found inconsistency in collected data on service utilization from the Directorate General of Health Services (DGHS) MIS. Moreover, it was not possible to obtain service utilization data by DGFP facilities from DGFP MIS.	• DGFP MIS needs to report the HNP service utilization data at different tiers of DGFP facilities other than only population services. • Both MIS need to place more emphasis on improving data quality.	
HEU lacks adequate data analysis capacity as well as understanding of required supplementary data. Capacity is also weak in terms of interpretation of data.	• In order to ensure regular updating of PER the HEU needs to appoint two officials solely for PER with basic skills in Microsoft Excel and provide them with requisite hands-on training.	• During the present PER HEU officials were involved in data analysis and report writing under the technical guidance of the World Bank Consultant